In re. the death of Michael Richard Drewry.

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust;**
1	**CORONER** I am Andrew McNamara, Assistant Coroner, for the coronial area of Nottinghamshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 3 May 2017 an Inquest was opened into the death of Michael Richard Drewry. That was concluded at the end of the inquest on 18 December 2017. The conclusion after the inquest was: Medical cause of death: *Hanging* How, when and where the deceased came by his death: *Shortly after 09.00 on 3 April 2017 Mr. Drewry was discovered by his wife at the foot of the stairs at the family home in Beeston, Nottingham. Wrapped around his neck and the newel post at the foot of the stairs was blue fabric taken from some pyjamas that had been fashioned into a ligature.* *Despite CPR, resuscitation and emergency hospitalisation, Mr. Drewry suffered an unsurvivable hypoxic brain injury. In consultation with his family Mr. Drewry's life sustaining therapy was withdrawn at 20.36 on 8 April 2017 and he died shortly after at 20.47 at the Queens Medical Centre Nottingham.* Conclusion of the jury as to death: *Mr. Drewry died as a result of injuries sustained from a self-administered ligature.*
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a background of periodic bouts of anxiety and low mood beginning in about 2007. His condition fluctuated and was, from time to time, well controlled with, amongst other drugs, fluoxetine. In January 2014 he required hospitalisation after an acute bout of anxiety in the workplace. Towards the conclusion of 2016 the deceased's mental health began to deteriorate and, by February 2017, he required emergency hospitalisation. Matters were exacerbated by the death of his sister during his period as an inpatient. The deceased was discharged into the community. On or about 9 February the deceased held a knife and expressed a desire to '*cut out the bad piece*' By late March the deceased's mental health began to deteriorate. On 30 March he had a panic attack, held a knife to his chest and said *'I would never do this but I can't live like this'*. Overnight in to 31 March he suffered a panic attack during which he injured his hand. His wife took him to A & E where he was prescribed diazepam. He was seen by a

	consultant psychologist at home on 31 March. The deceased's mood fluctuated and his wife rang the Crisis team in the early hours of 2 April 2017. He was seen at home at 10 am on 2 April 2017 by a nurse during which he explained how he had held a knife to his chest. During the consultation he calmed and denied strong urges to end his life. Medication was delivered later that day by a Community Support Worker who carried out no formal assessment of the deceased's mental state. The deceased remained anxious and outwardly stressed about an impending visit from a psychiatrist and certain domestic building works that were being done at the time. In the morning of 3 April 2017 the deceased and his wife discussed the renovation work; he then became distressed as a result of his clothing splitting and remained anxious whilst his wife showered. His wife subsequently discovered the deceased slumped at the foot of the stairs with a ligature fashioned from pyjamas around his neck and the newel post. He sustained fatal injuries as a result and died on 8 April 2017. Following his death Nottinghamshire Healthcare NHS Foundation Trust prepared a Quality Improvement Plan dated 22 June 2017. Within it were 6 recommendations which raised issues with basic healthcare practice including such fundamentals as accurate note-taking and the appropriate route to escalate concerns about a patient.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The failure of the Crisis Team to ensure consistency and continuity of care for the deceased, in particular the changing personnel who visited the deceased; (2) The failure of the Crisis Team to make accurate and prompt records of all consultations with the deceased; (3) The failure of the Crisis Team promptly to report/escalate any matters of concern to senior members of staff so that appropriate and timely steps could be taken in relation to the management of the deceased's care including, if necessary, hospitalisation;
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 February 2018. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Parties/Persons: 1. [redacted] 2. [redacted], Nottinghamshire Healthcare NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful

	or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**28 December 2017**	**Andrew McNamara**